

STATE PUBLIC HEALTH ACTIONS FOR PREVENTION GRANT OVERVIEW

December 5, 2014

Kari Majors, Health Systems and Disease Management Program Manager
Chronic Disease Prevention and Control Programs
DHHS, Division of Public Health
kari.majors@nebraska.gov; 402-471-1823

Overview of state grant

In July of 2013, Nebraska Department of Health and Human Services, Division of Public Health, Chronic Disease Prevention and Control Program (CDPCP) received grant funding for 5 years (July 2013- June 2018) from the Centers for Disease Prevention and Control (CDC) to:

- Improve the delivery and use of quality clinical and other services aimed at preventing and managing high blood pressure and diabetes.
- Increasing the links between community and clinical organizations to support prevention, self-management and control of diabetes, high blood pressures, and obesity.

Overview of local grant

In September 2014, the CDPCP received additional grant funding for 4 years (September 2014-September 2018) from CDC for local communities to conduct the same strategies comprehensively targeted at selected priority populations within their service areas. Selected Local Health Departments receiving this funding beginning November 2014 are:

- Douglas County Health Department
- Public Health Solutions
- South Heartland District Health Department
- Central District Health Department
- Two Rivers Public Health Department
- Panhandle Public Health District/ Scottsbluff County Health Department

Grant Components (3 Domains)

Domain 2:

Environmental Approaches to Promote Health

- Nutrition
- Physical Activity
- Obesity Prevention
- Breastfeeding
- School Health

Domain 3:

Health Systems Interventions

- Increase HIT/EHR AIU, MU Attestation
- Increase monitoring of quality measures (NQF 18&59)
- Increase use of team-based care
- Increase identification of undiagnosed hypertension within the health system
- Increase use of SMBP monitoring tied with clinical support

Domain 4:

Community/Clinic Linkages

- Diabetes Prevention Program (DPP)
- Diabetes Self-Management Education Program (DSME)
- Living Well (Chronic Disease Self-Management Program)
- Community Health Workers
- Community Pharmacists for MTM/Self-Management

Domain 3: Health System Intervention

- **Increase HIT/EHR adoption**
 - Working through contractor to engage approximately 5-7 clinics annually to assist in EHR adoption, implementation, upgrade and project management in preparation for “go live” and MU attestation.
- **Increase monitoring of clinical quality measures**
 - Working through contractors and partner organization to encourage and provide assistance to Primary Care Providers and Clinics in monitoring hypertension and diabetes measures NQF 0018 and NQF 0059, including their ability to generate and report on standardized quality measures.
 - Working through contractors and organizations to encourage and assist clinics in implementing quality improvement processes around improving hypertension and diabetes management and control.

Clinical measures – what are you currently collecting?

ABCS Clinical Measures Crosswalk

Measure	Measure Description	Aligned Initiatives	Domain
Aspirin Use	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic: Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic	<ul style="list-style-type: none"> • MU-CMS 164v2 • PQRS Measure #204 • NQF 0068 • ACO measure 	Clinical Process / Effectiveness
A1C	Diabetes Mellitus (DM): Hemoglobin A1C – Poor Control >9%: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9%	<ul style="list-style-type: none"> • MU-CMS 122v2 • PQRS Measure #1 • NQF 0059 • ACO measure 	Clinical Process / Effectiveness
Blood Pressure Control	Hypertension (HTN): Controlling High Blood Pressure: Percentage of patients aged 18 through 85 years who had a diagnosis of Hypertension (HTN) AND whose blood pressure was adequately controlled (<140/90) during the measurement year	<ul style="list-style-type: none"> • MU-CMS 165v2 • PQRS Measure #236 • NQF 0018 • ACO measure 	Clinical Process / Effectiveness
Cholesterol Control	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL: Percentage of patients aged 20 through 79 years whose risk factors* have been assessed AND a fasting LDL test has been performed *There are three criteria for this measure based on the patient's risk category: 1. High Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent 2. Moderate Level of Risk: Multiple (2+) Risk Factors 3. Lowest Level of Risk: 0 or 1 Risk Factor	<ul style="list-style-type: none"> • MU-CMS 61v3 and • MU-CMS 64v3 • PQRS Measure #316 • NQF – N/A 	Clinical Process / Effectiveness
Smoking Cessation	Preventive Care and Screening: Tobacco Use: Screening AND Cessation: Percentage of patients aged 18 years and older who were screened about tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	<ul style="list-style-type: none"> • MU-CMS 138v2 • PQRS Measure #226 • NQF 0028 • ACO measure 	Population / Public Health

Domain 3: Health System Intervention

- **Increase use of team-based care**
 - **Working through contractor with approximately 20 clinics annually to educate and engage staff in effective team-based care and patient-centered medical home components.**
 - One-on-One engagement to:
 - Assess baseline for patient-centered medical home (PCMH) transformation efforts
 - Assess team based care challenges
 - Determine training and facilitation needs
 - 2-6 hour Training session based on one-on-one practice engagement results in an interactive collaborative setting.
 - Practice support through collaborative conference calls among practices, emails and phone calls.
 - Site visit for each site for interactive activity and involvement.
 - 2 individual practice progress check-in calls with each clinic.

Recruitment and Commitment

- Discussion with each practice about the project
- Sign a simple partner and practice collaborative agreement to ensure commitment and outline of expectations

Partner and Practice Collaborative Statement of Work (SOW)
1. Project Details
Practice Name: Click here to enter text. Primary Contact/Team Lead: Click here to enter text. Physician Champion: Click here to enter text. Location: Click here to enter text. # of Sites: Click here to enter text. # of Providers: Click here to enter text.
2. Partner Commitment
<p>The Nebraska Department of Health and Human Services (DHHS) receives grant funding from the Centers for Disease Control and Prevention to:</p> <ul style="list-style-type: none">• Improve the delivery and use of quality clinical and other health services aimed at preventing and managing high blood pressure and diabetes.• Increase links between community and clinical organizations to support prevention, self-management and control of diabetes, high blood pressure, and obesity. <p>As part of the improving delivery and team-based care grant activities, DHHS has contracted with Remedy Healthcare Consultants (Sheila Richmeier, MS, RN, FACMPE), to deliver the following services both onsite and virtually to selected practices in Nebraska:</p>

Baseline PCMH self-evaluation

		July	Dec
Medical home element	Explanation of element	Rating - from 0-10 on below elements (0= no work done, 10= working well)	
Teamwork Leadership & Communication			
engaged leadership	PCMH leadership structure that supports continuous learning (2)		
communication	A...uilt for bi-directional communication to everyone about the change		
	ded for all staff members to be involved in the change &		

Please tell us about your site

Name of site	Address
	City
	Main phone line
	Website
Main contact person	
Main contact role	
Main contact phone line	
Main contact e-mail	
Specialty (FP, IM, Peds)	
Practice Management system	
EMR	
Registry used	
NCQA status (level 1,2,3)	

2 ½ page checklist – baseline on how practice functions as a PCMH

- Teamwork, leadership & communication
 - Enhanced access
 - Team based care
 - Quality improvement
 - Care management / chronic disease care
 - Care coordination
 - Patient centered care
- Rate practice on scale of 0-10

Implementation

- Review of PCMH evaluation, identify areas in need and prioritize
- Engagement of ACO or Umbrella Organization
 - Regular updates
 - Coordinated with their intervention
- Collection of metrics (HTN & DM)
- Collaborative meeting
 - Chronic disease care overview
 - Use of team to improve outcomes
 - Community health worker integration
- Site visits
 - Specific area of need
 - Focused intervention to help movement
- Progress calls

Additional Overlapping Strategies

- **Increase use of self-measured blood pressure (SMBP) monitoring tied with clinical support**
- **Increase use of healthcare-extenders (CHWs and Pharmacists) for MTM and self-management of hypertension and diabetes**

Performance Measures

- Percentage of patients within health care systems with EHRs appropriate for treating patients with high blood pressure
- Percentage of patients within health care systems with systems to report standardized clinical quality measures for the management and treatment of patients with high blood pressure.
- Percentage of patients within healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control
- Percentage of patients within health care systems with policies or systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes
- Proportion of adults with high blood pressure in adherence to medication regimens
- Proportion of adults with known high blood pressure who have achieved blood pressure control
- Reduce death and disability due to diabetes, heart disease and stroke by 3% in implementation area

**To discuss opportunities for collaboration,
partnership or additional information, please
contact:**

Kari Majors, Health Systems and Disease Management Program Manager
Chronic Disease Prevention and Control Programs
DHHS, Division of Public Health
kari.majors@nebraska.gov; 402-471-1823

Jamie Hahn, Manager, Chronic Disease Prevention and Control Program
DHHS, Division of Public Health
Jamie.Hahn@Nebraska.gov; 402-471-3493